REQUEST TO RELEASE INFORMATION

State Form 40223 (R2 / 12-97)

INDIANA PROTECTION AND ADVOCACY SERVICES

I hereby request that: _____

who is the person or organization in custody of information, release the following information:

_____

pertaining to: _____
(*Name of individual about whom information pertains*)

date of birth of individual: _____

address: _____

_____

to: _____
(*Name of person or organization in need of information*)

at: _____
(*Address of person or organization in need of information*)

For the purpose(s) of: _____

_____
with the understanding that this information will not be used or disclosed for purposes not specified above.

Signature of individual about whom information pertains or person authorized by statute	Date (*month, day, year*)
Printed name of signatory	
Relationship of signatory to individual about whom information	
Address of signatory	

The patient's consent to release of mental health records is subject to revocation at any time, except to the extent that action has been taken in reliance on the patient's consent.

This consent will expire one hundred and eighty days (180) from the date of signature, unless consent is revoked prior to that date.